Transmittal Letter

July 30, 2012

Dear Reader,

The purpose of this letter is to officially transmit the Ombudsman for Medicaid Managed Care FY '11-12 Annual Report. MAXIMUS, Inc. administers the Ombudsman Program under contract with the Colorado Department of Health Care Policy & Financing.

The Medicaid Managed Care landscape continued to evolve during FY11-12. Not only has Medicaid enrollment continued to increase due in large part to the lingering economic recession, but new programs were also introduced. In May of 2012 a new Medicaid eligibility category, Adults without Dependent Children (AwDC) was introduced. The goal of this program is to provide Medicaid benefits to a demographic previously excluded from coverage but in need of healthcare services. These Medicaid clients will fall under the scope of the Ombudsman as they are considered part of Medicaid Managed Care due to enrollment into the Accountable Care Collaborative (ACC).

Along with being a resource for managed care clients, the Ombudsman staff also gathers data regarding the issues and outcomes associated with each Ombudsman case. This annual report summarizes trends in complaint data from the client's perspective when dealing with either their medical or mental health plans.

The hope of the Ombudsman office is that such information will be useful in efforts to improve programs offered to Medicaid clients. The fewer obstacles a client faces when seeking care the fewer complaints they are likely to have about their care. This of course benefits not only the clients, but providers as well.

It is our hope that this report will prove useful to State policy-makers and administrators, as well as to health plans and advocates in their shared goal to continually elevate the level of care received by Medicaid managed care members.

Respectfully submitted,

Janine Vincent, Ombudsman Manager
Colorado Medicaid Managed Care Ombudsman Program
Health Services West, MAXIMUS

OMBUDSMAN FOR MEDICAID MANAGED CARE – ANNUAL REPORT

This report summarizes FY 11-12 activities for the Ombudsman For Medicaid Managed Care operated by MAXIMUS. It contains information regarding the types of contacts received by the Ombudsman and specific complaint data. This report is specific to operational activity for July 1, 2011 through June 30, 2012.

Type of Contact	Fiscal Year 2012
Total calls (ACD report)	733
Total calls to initiate cases	167
Out of Scope/Fee-for-service/ref. to other agencies/info only	113
Total Existing client calls	453
Face to Face client contact	3
Complaints received via	
Mail	0
Fax	0
Email	4
Complaint types (inquiries and cases)	
BHO	63
MCO	45
PCPP	10
Accountable Care Collaborative	49
Information only provided to fee-for-service clients	113
Req. Written Material	0
Out of Scope Client calls referred to outside agencies	
Department Staff	83
Board of Medical Examiners	0
Office of Administrative Courts	4
Div. of Insurance, Legal Aid	6
Department Contacts	0
Medicaid Managed Care Managers	0
Department Quality Improvement Section	0
Department of Regulatory Agencies	8
Number of Clients with Disabilities	189
Number of Clients with language difficulties	1
Withdrawal of Request/No Response	44

THE OMBUDSMAN FOR MEDICAID MANAGED CARE

The purpose of the Ombudsman for Medicaid Managed Care is simple: to assist clients enrolled in Medicaid Managed Care programs. The Ombudsman is available to assist those clients who experience problems when the health care system does not function normally or the client experiences problems accessing the medical or mental health care services they are seeking.

While the purpose of the Ombudsman is simple, the role of the Ombudsman may not be so much so. Often times the role of the Ombudsman is to help the interested parties work through misunderstandings, or assisting in the coordination of care services between health plans, providers, and other agencies to resolve the client's problems. On occasion it falls upon the Ombudsman to educate members, health plans and providers about Medicaid rules and policies.

Managed care clients contact the Ombudsman with questions regarding the complicated and sometimes confusing business of navigating Medicaid managed care. Consistent with prior years, a very large portion (64%) of contacts in Fiscal Year '11-12 were in regard to access to care complaints; approximately 17% related to issues of quality, 15% were concerning health plan benefit issues and 4% were in regard to rude treatment.

The Ombudsman adds value to the Colorado Medicaid system with its impartial, independent, and confidential handling of each member's concerns. It also accumulates and reports qualitative information to State policy makers, who use it to manage health plans and to improve program design and processes.

An independent Ombudsman is especially important in a public healthcare system designed to assist the underserved and disadvantaged. It is imperative to balance the business goals of service providers with the health care needs of clients. When a health plan is unable to help clients solve their problems, some clients may need additional help from an entity outside the framework of the health plan. An independent office such as the Ombudsman can be of vital importance in assisting clients in framing their complaint to the plan. In addition, the Ombudsman can assist the client in identifying solutions and facilitating dialogue between provider and client. As an objective and impartial third party, the Ombudsman can offer a perspective or potential solutions which may otherwise go overlooked.

The purpose and focus of this annual report is upon the managed care enrollee's problems with their health plans. While the purpose of the report could be interpreted as negative, the intent is quite contrary. Information gathered regarding the breakdown of performance in health plans gives plan and program administrators vital information with which to improve Medicaid benefits and services to their members.

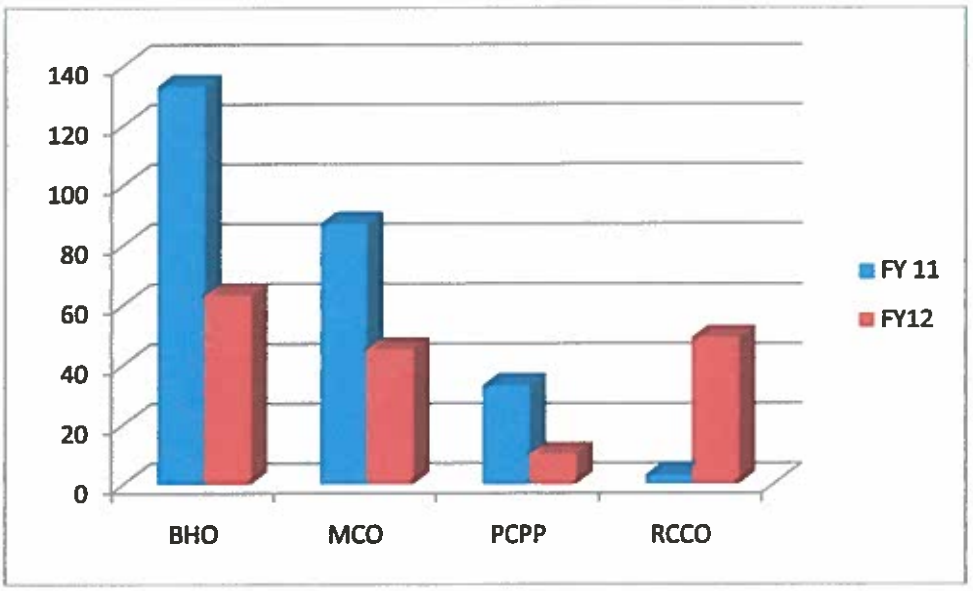
BHO, MCO, PCPP or RCCO?

Medicaid Managed Care Health Plan	Total Cases/Inquiries FY '11-12	Percentage
BHO	63	38%
MCO	45	27%
PCPP	10	6%
RCCO	49	29%

The data above is consistent with that reported by the OMMC in previous reports during FY '12. The most significant increase is the number of contacts the OMMC received regarding a RCCO. Between July 1, 2011 and June 30, 2012, over 137,000 passive enrollment letters were sent to Medicaid clients enrolled into that program. Based upon this, the OMMC anticipates a continued steady increase in the number of RCCO contacts received from clients.

The OMMC was also contacted by clients with concerns regarding access to health care under Medicaid fee-for-service or establishing Medicaid eligibility. The number of contacts received fee-for-service clients has been steadily declining due to the increase in staff at Medicaid Customer Service. The Ombudsman provides information and referrals to every client but tracks these cases which fall outside of managed care less formally than those clients who raise concerns regarding managed care plans.

Finally, it is very important to note that BHOs covered approximately 95% of the 636,587 Medicaid eligible clients in FY11 -12 which does account for the slightly higher number of contacts the OMMC receives regarding a client's BHO. With the implementation of the ACC Program, the total number of individuals enrolled into managed care (MCO, PCPP or ACC options) grew by 133%. A total of 34% of Medicaid clients were serviced by a physical managed care option during FY 11-12 as opposed to only 16% during FY 10-11.



The Ombudsman in an ever changing healthcare Landscape

The Ombudsman operates within a dynamic healthcare landscape. The Ombudsman program underwent several internal changes during the course of FY 10-11. Between October and March of FY'10-11 the Ombudsman experienced a complete change of staff. However the OMMC experienced no turnover during FY 11-12. This has allowed the Ombudsman to continue evaluate the manner in which cases are handled and recorded, as well as the vision and role of the Ombudsman program in light of the implementation of both the ACC and AwDC (whose members will all be enrolled into the ACC).

Along with the internal changes the OMMC has experienced during the past two fiscal years, there have been significant external changes as well. The total number of individuals enrolled into Medicaid managed care (including MCO, PCPP and the ACC) grew by a whopping **133%** during FY12, due in large part to the implementation of the ACC program. Along with that, the total number of Medicaid clients serviced by a physical managed care option jumped from 16% to 34% in that same time frame.

The Accountable Care Collaborative (ACC) & Adults without Dependent Children (AwDC)

As discussed in the OMMC Annual Report for FY 10-11, the State of Colorado initiated the Accountable Care Collaborative (ACC) in April 2011. The focus of this program is to assist managed care entities in adopting a client-centered approach that provides efficient and coordinated care to improve the overall health of its members. This model of care is unique to the State of Colorado and differs from capitated managed care. The ACC invests directly in regional care coordination and in community infrastructure to support physicians and care teams. The new model operates by incentivizing measurable improvements in client health and reduction in avoidable health care costs. Features of the ACC include:

- A medical home for all clients;
- enhanced care management, data, and other provider supports;
- provider coordination across the spectrum of a client's health needs; and
- statewide data and analysis available regionally

The definition of managed care in Colorado Medicaid has shifted with the implementation of this program.

The Adults without Dependent Children expansion program was initiated in May, 2012. This expansion program is intended to provide Medicaid benefits to a new category of individuals who were not previously eligible. Eligible participants must have an income at or below 10% of the Federal Poverty Level (FPL) or approximately $90 per month. AwDC clients will automatically be enrolled into the ACC and therefore will be eligible to receive assistance from the OMMC.

The role of the Ombudsman within the ACC and AwDC will be of utmost importance. It is projected that nearly all Medicaid clients may ultimately be enrolled in the ACC. This would, of course, increase the Ombudsman client base dramatically. Not only would the number of potential clients rise significantly, but the number of providers with whom the Ombudsman collaborates would increase sharply as well. The implementation of the ACC presented unique challenges for the Ombudsman. As was noted in several previous reports, initially the OMMC received calls which required client and provider education about respective rights and responsibilities. The OMMC also took several ACC related calls in which clarification regarding Medicaid eligibility was required for newly enrolled clients. As with any new program there was a period during which it was unclear who the OMMC was to contact at each RCCO regarding client issues. HCPF worked very closely with the RCCOs to provide the OMMC with contact information for the appropriate parties as well as clarify the role of the Ombudsman to their staff. The Ombudsman has experienced an increase in the complexity of ACC cases it handles and this is to be expected as clients remain enrolled in the program.

Appeal & Grievance Processes

When Medicaid Managed Care members are unhappy about their care, there are two avenues through which they may seek resolution:

- file an appeal; or
- submit a grievance

The nature of the member's complaint determines which remedy is appropriate. Both grievance and appeal processes have several levels of review and each health plan/administrative body has its own timeliness requirements.

The client may file an ***appeal*** only in response to one of the following actions by the MCO/BHO (or its providers) after receiving a Notice of Action from the health plan:

- Denying or restricting authorization of a requested service, including the type or level of service;
- Reducing, suspending or terminating a previously authorized service;
- Denying all or part of a payment for a service (except payment denials issued by a mental health prepaid inpatient health plan);
- Failing to act within regulatory timeframes; or
- Denying a member's request to obtain out-of-network services in areas with only one MCO.

Regulations require BHOs and MCOs to send a written Notice of Action (NOA) to clients whenever any of the above actions or situations occurs.

Clients may make in-plan appeals with the BHO and MCO. They may also choose to file a subsequent or concurrent request for a State Fair Hearing with the Office of Administrative Courts. An external Administrative Law Judge (ALJ) hears these appeals. Every health plan and the ALJ appeal process has its own specific timelines within which both the health plan and the clients must act while moving through the appeal process.

A client's recourse if s/he is dissatisfied with an ALJ's decision is to seek a reversal by the Department during Final Agency Action review or to file a lawsuit in federal district court.

A ***grievance*** is used to express a Medicaid member's dissatisfaction about anything ***other*** than the actions previously described, including but not limited to: the quality of care or services, or interpersonal relationships such as provider rudeness or failure to respect the member's rights.

Grievances may be submitted to the BHO or MCO, either by the client in person or with the assistance of an advocate, provider, or the Ombudsman. In a grievance acknowledgement letter, the BHO or MCO notifies the client of their procedures for handling grievances, related timelines, and the client's rights.

A grievance may be filed when:

- A client is unsatisfied with the services that they are receiving;
- A client is in need of assistance in correcting a medical record error;
- A client is requesting a new provider due to their dissatisfaction with their current provider;
- A client is not receiving services in a timely manner

If a client is unsatisfied with the resolution provided by the plan, the client may request the Department's review of the grievance resolution. The Department's decision on a grievance is final.

Levels of Resolution

Regardless of the issue presented to the Ombudsman, the goal is always to resolve each complaint at the lowest level possible. Ideally, an issue is addressed through member education and information, and referral to the appropriate agencies when necessary. Should it not prove possible to resolve an issue at the very lowest level of resolution, it may be achieved via an informal in-plan resolution. This may include assisting the client with service requests through care coordination with either the provider or health plan. Should these efforts not prove to be successful, the Ombudsman may assist the client in seeking a formal in-plan resolution. Should an issue be escalated to this level, the Ombudsman may assist the client with filing grievances as well as appeals to decisions made by an MCO or BHO. Finally, the client may choose to advance to the highest level of resolution; requesting a hearing before an Administrative Law Judge. The table below illustrates the number of cases the Ombudsman handled at each level of resolution during FY'11-12.

Level of Resolution	Total Cases/Inquiries FY '11-12	Percentage
1. Education, information & referral	167	69%
2. Informal in-plan resolution	50	21%
3. Formal in-plan resolution	20	8%
4. State Fair Hearing request	5	2%

It is the best interest of all parties involved that each case or inquiry be resolved at the lowest possible level of resolution. Should a client's issue go unresolved for an extended period of time, not only is it likely that the client may be going without needed treatment, but it may damage the provider/client relationship irreparably. There may be significant ramifications for the health plan or provider as well. A client who feels as though their complaint is not being addressed adequately is more likely to require a higher level of resolution to resolve their problem. This in turn will result in increased cost to the health plan in terms of time and financial resources.

When working to resolve an issue for a client regarding their BHO, MCO, or RCCO the Ombudsman often has to take on the role of investigator. It may require a significant amount of clarification to determine what the member's complaint is, and the resolution they are seeking. For example, a client who believes that a requested service is being denied may approach the Ombudsman for assistance but may not have received a formal Notice of Action from their health plan. In certain instances an NOA may not have been issued as a passing comment from a client to provider was not recognized as a formal request, therefore it is not being formally denied. Such situations often only require clarification regarding that services the client is seeking and communicating that to the provider/health plan.

REASONS TO CONTACT THE OMBUDSMAN

Reasons to Contact Ombudsman	Cases FY '11-12	Percentage
1. Access to Care	156	64%
2. Denial of Benefits	35	15%
3. Quality of Care	42	17%
4. Rude Treatment	9	4%

It is clear that FY'11-12 was consistent with FY'10-11 in regard to the high percentage of clients contacting the Ombudsman with issues surrounding access to care. These issues can be as simple as a client needing to be educated on how to access care from either their BHO or MCO, to a client experiencing a high level of difficulty locating a specialist capable of managing very complex healthcare needs. There are two groups who contact the Ombudsman quite often for the reasons listed above: children in need of residential treatment and those with disabilities.

Residential Treatment and CMHTA

Residential treatment and CMHTA were discussed at great length in the FY'09-10 annual report, and more briefly in the FY'10-11 annual report as well. The OMMC continues to see these cases, though it was on a very limited basis during FY'11-12. When residential treatment is denied through a BHO, the Ombudsman will assist the parent s of these children in navigating not only the BHO appeals process but the Child Mental Health Treatment Act (CMHTA) appeals process as well. CMHTA is designed to provide parents of children with mental health needs access to residential and other treatment services regardless of their Medicaid status. A CMHTA assessment for residential treatment may be used in conjunction with BHO residential treatment assessments to determine if a child meets the requisite criteria for such a high level of care. Should the two assessments differ and the parents choose to appeal the BHO decision to the ALJ seeking residential treatment, the CMHTA assessment supporting that level of care for the child may be beneficial.

Disability

The Ombudsman receives a very high number of calls from individuals with disabilities. Approximately 78% of the cases and inquiries addressed by the Ombudsman in FY'11-12 had a disability code associated with their Medicaid eligibility or were self reported. The range of disabilities recorded is very broad, and includes many clients with mental illness, chronic health problems, traumatic brain injuries as well as developmental disabilities. The high volume of contacts from individuals with disabilities speaks volumes to the ease with which they are able to navigate the Medicaid managed care system. This may be due to both the complexity of the managed care plans as well as an already limited ability to navigate such networks on the part of the clients.

SUMMARY

Much like the previous fiscal year, FY '11-12 was a year filled with changes both internal and external for the Ombudsman. Though the OMMC did not experience any staff changes, the manner in which cases are tracked and reported continues to evolve. FY'11-12 also saw an indefinite suspension of the OMMC Advisory Board. The implementation of the ACC program has started to change the landscape of managed care in Colorado, as will the AwDC expansion program implemented this fiscal year. Both will continue to impact the work of the Ombudsman by dramatically increasing the managed care client population the Ombudsman may assist. This will also allow the Ombudsman to continue assisting providers in developing grievance and appeals processes for their clients.

Despite the changes previously discussed there was also quite a bit of consistency for the Ombudsman this fiscal year. The Ombudsman continued to see a very large number of cases regarding access to care problems as well as a significant number of clients with disabilities. The OMMC continued to find resolution the majority of the time at the lowest level of resolution, which is in the best interest of all parties involved.

The Ombudsman continues to play a vital role within Medicaid managed care. It is a resource for those clients who would otherwise have very few options for assistance in navigating both the managed care system, and grievance and appeals processes. It is the hope of the Ombudsman that the information contained in this report will prove useful to State policy-makers and administrators, as well as health plans and advocates in the shared effort to make Medicaid managed care better able to serve its members.

Appendix 1 – Case Vignettes

The following case examples demonstrate the involvement of the Ombudsman to ensure that clients are afforded all levels of appeal that are available to resolve Medicaid managed care issues.

Case Example #1

Background

The mother of an adult client called seeking assistance from the Ombudsman regarding the discharge of the client from a mental health hospital to a homeless shelter. The client's mother did not feel that the client was stable enough for discharge and did not feel that a homeless shelter would be a safe option for the client.

Story

The client's mother called extremely concerned that her daughter was going to be released from a mental hospital and as the client had no home would be forced to enter a homeless shelter. The client's mother did not feel that the client was stable enough to be released, nor that a homeless shelter would be a safe option for the client given her diagnoses and lack of skills to care for herself on her own. Also complicating matters was the inability of the hospital to find any centers that would accept the client due to her medical conditions and prior assaultive behaviors.

The Ombudsman assisted the parents, who also had medical power of attorney for the client, in contacting both the client's mental health center and behavioral health organization to request services for the client and determine alternatives for the client besides entering a homeless shelter. It was also communicated to the Ombudsman by the director of the mental health hospital that they were not aware that the Ombudsman was available to assist in such situations, nor were the aware of the existence of the BHO. A significant amount of education was provided to clarify the role of the Ombudsman, the BHO and the Medicaid managed care delivery system as well.

The Ombudsman assisted the client's parents in working with not only the client's mental health center, but also the BHO and the RCCO to coordinate services for the client. Since the client was also enrolled in a waiver program, the Ombudsman also worked to ensure that the client would receive those additional services.

As the client had many very complex needs, a great deal of coordination and cooperation was needed between all parties. The Ombudsman also assisted the client's parents in taking the steps necessary to find housing for the client where she could begin to learn to live on her own. The Ombudsman was in almost constant contact with the mental health hospital, mental health center, BHO, RCCO as well as the parents and Long Term Care Options to coordinate services for the client.

The client's parents were successful in finding a suitable apartment for the client and the needed services were established through all of the aforementioned parties to assist the client. The client was able to move into the apartment and did fairly well for a short period of time. The client was hospitalized not long after moving into her own apartment and the challenge then became stepping the client down so as to make sure she could re-enter her home. The client's parents also requested that the client be seen at a different mental health center which the BHO was more than willing to accommodate. It became clear that the client's parents were not totally comfortable with the client living on her own and felt she needed more oversight than she was receiving in her apartment. Complicating matters was the lack of communication between the mental health center, caseworker and Long Term Care Options. The client was also not cooperating regarding giving her authorization to change mental health centers.

Ultimately, based upon a reduction in services to the client through the mental health center however this was not an issue as the client's parents opted to have the client placed in a long term care facility.

Outcome:

In light of the placement of the client into a long term care facility, the Ombudsman's services were no longer needed by the client or parents to obtain services. The client's parents were advised that should they need assistance in the future it would be available through the OMMC.

Conclusion:

This case illustrates the importance of care coordination for very high needs clients. It also illustrates the important role the Ombudsman can play when assisting clients in requesting services from various providers and facilitating the communication between several providers.

Case Example #2

Background:

The Ombudsman was contacted by the mother of a juvenile client, and the parents were seeking residential treatment services for the client at a specific center. This specific level of treatment had been requested several times over approximately a three year period. Complicating matters was the number of parties involved as the client had become involved with the legal system.

Story:

The client's parents were seeking residential treatment at a specific center based upon his failing at RTC on three separate occasions and they felt it was due to the lack of appropriate treatment he received in light of his mental health diagnoses. The parents had been told that the client's mental health center did not contract with the specific center being requested; however a denial letter had never been issued. The client's probation officer was also trying to determine whether or not to detain the client based upon failed drug tests. The probation officer had advocated for the particular residential treatment center as well, to no avail.

The Ombudsman began the process of assisting the parents which meant contacting both the mental health center and BHO. What became clear very quickly was that the IMPACT team that had been working with the client had not been providing progress notes to the client's therapist at the mental health center. Nor had the client's parents been advised that the client had a therapist at the mental health center. The mental health center agreed to investigate the lack of documentation and communication.

In the process of the assisting the parents with their request for an assessment of the client by the mental health center it was communicated that there was an active social services case regarding the client and parents. Therefore the decision regarding RTC was out of the hand of the mental health center unless the case had actually been closed. The parents confirmed that the case had in fact been closed and they did have custody of the client.

While the Ombudsman was working to obtain an assessment for the client, the probation officer advised the parents that she was inclined to take the client into custody if RTC was not approved sometime very soon. The OMMC began working to obtain a rush decision from the BHO regarding RTC. The client's parents worked to provide the mental health center with all necessary medical records needed to issue a determination regarding RTC. The mental health center therapist also advised that the probation officer could take the client into custody and attempt to have him committed to obtain RTC should the client refuse it otherwise.

The OMMC also learned that the client and the parents were working with a PRT team which includes the mental health center, social services, the probation team and the parents. The mental health center also noted that services had been offered by both the mental health center and social services which had been refused by the parents. This was disputed by the probation officer who stated the parents had not refused services.

While continuing to assist the parents, the OMMC was informed that the probation officer had been instructed that she may not speak with OMMC, however a reason was never given. The client's mother felt that it was something "political" within the PRT team and that she felt they were being discriminated against because several parties that were involved were under the impression they still had the means to pay for treatment for the client on their own. She stated they had both been laid off and were trying to start a new business and were not in the same stable financial position they had been in the past.

The client's parents were very concerned that the PRT team would again deny RTC and that placement with the Department of Youth Corrections was not appropriate. The OMMC advised the parents that they were also entitled to a CMHTA evaluation for RTC for the client. That had to be requested through and provided by the mental health center. This had been requested by the parents before, however the client had not been a Medicaid client at that time. The request was made.

Complicating matters, while awaiting the decision regarding RTC, the client's behavior escalated and he ultimately was placed in a youth detention center. The parents were also informed by the BHO at this time that out-patient treatment would be the most appropriate given that the client had failed in residential treatment several times prior. It was also noted by the parents that finding a center that would accept the client at this time would be difficult given his suicide threats and attempts.

Based upon the BHO denial, the parents decided to appeal that decision through BHO and also file a request for a hearing before an ALJ. They also wanted to move forward with their appeal of the CMHTA evaluation. The parents had also provided medical records to a doctor at another residential treatment center for review as they had determined that particular center would be the best fit for the client.

While awaiting the decisions on the appeals filed as well as a hearing date before an ALJ, the client's parents also began investigating taking him off of Medicaid all together in an effort to obtain services more easily. They had also received notification that their desired center would accept the client and the client had indicated via a letter that he wanted treatment.

The parents were notified that the doctor reviewing the CMHTA evaluation had indicated that the client did in fact need residential treatment, however is not able to determine who should provide that service. It was also becoming questionable whether the client would still be eligible for Medicaid coverage as his parent's financial situation was improving. The client had been granted permission to visit his grandmother out of state for a couple of months.

The client's parents were informed not long after the client leaving to visit his grandmother that their desired center had changed their position and would no longer accept the client as they were not well equipped to provide him with the treatment necessary. The client had indicated he would prefer to stay with his grandmother and the client's parents had found a therapist willing to treat the client. In light of these events, the parents also withdrew their request for a hearing before the ALJ.

Outcome:

The client was never placed in residential treatment in Colorado as he relocated prior to a hearing before the ALJ. The client's parents were able to find him adequate treatment in his new location.

Conclusion:

This case illustrates just how difficult it can be for clients to obtain higher level services at times. The involvement of several parties and a lack of communication between the PRT team and the mental health center also greatly complicated matters. This case also illustrates how beneficial it can be for all parties to have the involvement of the OMMC who can facilitate communication and assist the client in navigating the often very confusing Medicaid appeals system.